United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
	)	
and	)	**Docket No. 18-1792**
	)	**Issued: September 16, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Oklahoma City, OK, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 24, 2018 appellant filed a timely appeal from a September 12, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that following the September 12, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met his burden of proof to establish more than 30 percent permanent impairment of the left lower extremity and 46 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

FACTUAL HISTORY

On November 12, 2002 appellant, then a 54-year-old carpenter, filed a traumatic injury claim (Form CA-1) alleging that on November 7, 2002 a window unit he had been repairing tipped and pulled him forward while in the performance of duty. OWCP assigned the claim File No. xxxxxx564. It accepted that the November 7, 2002 employment incident had resulted in a lumbar strain, lumbar spondylosis, and spinal stenosis.

Appellant underwent core decompression of the right hip on December 19, 2002, unrelated to his federal employment. In 2003, he underwent bilateral total hip arthroplasties due to nonoccupational avascular necrosis.

On April 30, 2008 appellant filed an occupational disease claim (Form CA-2) alleging that federal employment duties, including repetitive heavy lifting on or before April 8, 2008, had caused bilateral hip pain. OWCP assigned the claim File No. xxxxxx075. It accepted that appellant had sustained bilateral hip and thigh sprains. Appellant retired from the employing establishment effective July 25, 2008.

On October 27, 2008 under File No. xxxxxx564, appellant underwent authorized L4-5 and L5-S1 anterior lumbar discectomies with instrumentation, plate fixation, and bone allograft. He underwent a revision laminectomy and fusion from L4-S1 on October 28, 2010 with removal of instrumentation. On December 8, 2010 appellant underwent surgical reexploration of the fusion site with dural repair to address a cerebrospinal fluid leak. He required a second dural repair on January 25, 2011.

On January 5, 2012 OWCP administratively combined File No. xxxxxx564 and File No. xxxxxx075. It designated File No. xxxxxx564 as the master file. OWCP also expanded its acceptance of the claim under File No. xxxxxx564 to include nonunion (pseudarthrosis) of lumbar fusion.

By decision dated April 4, 2013, under File No. xxxxxx564, OWCP granted appellant a schedule award for 28 percent permanent impairment rating of each lower extremity due to sensory and motor deficits in the L4, L5, and S1 nerve roots bilaterally. The period of the award, equal to 161.28 weeks of compensation, ran from March 10, 2013 through April 11, 2016.

On October 5, 2015 appellant underwent a revision right hip arthroplasty.

On September 28, 2016 appellant filed a claim for an additional schedule award (Form CA-7) under File No. xxxxxx075.[3] In support of his claim, he submitted a May 23, 2016 impairment rating by Dr. John W. Ellis, a Board-certified family practitioner, who found that appellant had attained maximum medical improvement (MMI). Referring to Table 16-4 (Hip Regional Grid) at page 515 of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),[4] he opined that the accepted employment injuries under both File Nos. xxxxxx564 and xxxxxx075 had caused 59 percent permanent impairment of each lower extremity due to two right hip arthroplasties and one left hip arthroplasty.

In an October 27, 2016 report, Dr. Paul D. Maitino, an attending Board-certified orthopedic surgeon, opined that appellant had attained MMI in the right hip. He opined that according to Table 16-4, appellant had 28 percent permanent impairment of the right lower extremity due to right hip arthroplasty with moderate residual symptoms.

On April 26, 2017 OWCP obtained a second opinion from Dr. Michael S. Brown, a Board-certified physiatrist, regarding the appropriate percentage of lower extremity permanent impairment originating in the spine. Dr. Brown reviewed a statement of accepted facts (SOAF) and the medical record, and opined that appellant had attained MMI. On examination, he noted that appellant ambulated with a walker. Dr. Brown observed a normal range of bilateral hip motion, 4/5 strength throughout both lower extremities, and noted appellant's symptoms of pain and paresthesias radiating into both lower extremities. He diagnosed bilateral L4, L5, and S1 radiculopathies, failed back syndrome following multiple surgeries, left hip strain, a history of nonoccupational bilateral hip arthroplasties in 2003, and revision right total hip arthroplasty. Utilizing *The Guides Newsletter*, Rating Spinal Nerve Extremity Impairment Using the Sixth Edition (July/August 2009) (*The Guides Newsletter*) and Table 16-11 (Sensory and Motor Severity) at page 533 of the A.M.A., *Guides*, Dr. Brown found bilateral mild sensory and motor deficits at the L4 level equaling 9 percent permanent impairment of each lower extremity; bilateral severe sensory and mild motor deficits at the L5 level equaling 13 percent permanent impairment of each lower extremity, and bilateral moderate motor and sensory deficits at the S1 level equaling 12 percent impairment on the right and 13 percent impairment on the left. He noted that according to page 3 of *The Guides Newsletter*, combined motor and sensory impairment could not exceed 13 percent for one level, and the combined impairment could not exceed 56 percent for both lower extremities. Dr. Brown therefore found 28 percent permanent impairment of each lower extremity due to spinal nerve root impairment.

Regarding the right hip, Dr. Brown found a class of diagnosis (CDX) of 2 for a total right hip arthroplasty with a good result. He noted a grade modifier for functional history (GMFH) of 3, a grade modifier for findings on physical examination (GMPE) of 0, and no applicable modifier for clinical studies (GMCS) applied. Utilizing the net adjustment formula, (GMFH-CDX) + (GMPE-CDX), or (3-2) + (0-2) resulted in a net modifier of -1, which lowered the default grade of C downward to B, equaling 23 percent permanent impairment of the right lower extremity. Regarding the left hip, Dr. Brown found a class 1 impairment for a left hip strain, with a GMFH

[3] On February 21, 2017 OWCP expanded its acceptance of the claim under File No. xxxxxx564 to include male erectile dysfunction, neuromuscular dysfunction of the bladder, urinary urgency and frequency, and neurogenic bowel.

[4] A.M.A., *Guides* (6th ed. 2009).

of 3 and a GMPE of 0. Applying the net adjustment formula, or (3-1) + (0-1), resulted in a net modifier of 1, which raised the default grade of C upward to D, equaling 2 percent permanent impairment of the left lower extremity. For the right lower extremity, Dr. Brown combined the 28 percent spinal nerve root impairment and the 23 percent right hip impairment to equal 45 percent permanent impairment of the right leg. For the left lower extremity, he combined the 28 percent spinal nerve root impairment with the 2 percent impairment for a left hip strain to equal 29 percent permanent impairment of the left leg.

In a report dated May 27, 2017, Dr. Morley Slutsky, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed Dr. Brown's April 26, 2017 impairment rating. He opined that based only on the employment injuries accepted under OWCP File No. xxxxxx075, appellant had 30 percent impairment of each lower extremity. The DMA noted that Dr. Brown's report had not provided adequate clinical findings to assess bilateral hip impairment.

By decision dated August 25, 2017, under File No. xxxxxx075, OWCP granted appellant a schedule award for an additional 2 percent impairment of each lower extremity, for a total 30 percent permanent impairment of each leg. The period of the award, equal to 11.52 weeks of compensation, ran from April 26 to July 15, 2017.

On September 6, 2017 appellant requested a review of the written record by an OWCP hearing representative.

By decision dated December 7, 2017, under File No. xxxxxx075, an OWCP hearing representative set aside the August 25, 2017 schedule award decision and remanded the claim to obtain clarification from Dr. Brown regarding appellant's bilateral hip impairment, a subsequent review by a DMA, and the issuance of a *de novo* decision.

In a report dated January 8, 2018, Dr. Ellis opined that appellant had 37 percent permanent impairment of each leg for total hip arthroplasty according to Table 16-4. Combined with the 28 percent previously awarded for spinal nerve root impairment, he found 55 percent impairment of each lower extremity.

Dr. Brown provided a supplemental report dated March 30, 2018. He explained that he did not record specific range of motion values for the bilateral hips when he had examined appellant on April 26, 2017. Dr. Brown noted that he had assessed a GMPE of 0 based on a normal range of motion in both hips.

OWCP referred appellant to Dr. Brown for an updated impairment rating. In a report dated June 28, 2018, Dr. Brown opined that appellant had attained MMI. He obtained range of motion measurements for both hips based on the maximum range among three trials performed after a warm-up. For both hips, Dr. Brown observed 110 degrees flexion, 0 degrees extension, 50 degrees adduction, and 40 degrees external rotation. He found 30 degrees internal rotation in the right hip and 40 degrees internal rotation on the left. Dr. Brown reiterated his calculation of 45 percent permanent impairment of the right lower extremity and 29 percent permanent impairment of the left lower extremity utilizing the identical tables and grading criteria as set forth in his April 26, 2017 report.

On July 16, 2018 OWCP requested that a DMA review Dr. Brown's updated report and provide an impairment rating for both lower extremities.

In a report dated July 25, 2018, the DMA reviewed Dr. Brown's June 28, 2018 report. He concurred that appellant had attained MMI as of June 28, 2018. The DMA also concurred with the bilateral L4, L5, and S1 nerve root impairment percentages found by Dr. Brown, but calculated that they equaled 30 percent lower extremity impairment and not 28 percent as Dr. Brown had found. For each lower extremity, he utilized the Combined Values Chart to combine the 13 percent impairment value for L5 with the 12 percent impairment for S1 to equal 23 percent, then combined the 9 percent L4 impairment to equal 30 percent permanent impairment of each lower extremity. The DMA did not include an impairment rating for the left hip arthroplasty as it was not the most impairing diagnosis for the left hip region, resulting in a total 30 percent permanent impairment of the left lower extremity. He also concurred with Dr. Brown's calculation of 23 percent permanent impairment of the right lower extremity due to hip arthroplasty with moderate residual symptoms. The DMA combined the 30 and 23 percent impairments for the right lower extremity to total 46 percent.

By decision dated September 12, 2018, OWCP granted appellant a schedule award for 16 percent permanent impairment of the right lower extremity in addition to the 30 percent previously awarded, for a total of 46 percent permanent impairment of the right lower extremity. It further found that appellant had not sustained impairment of the left lower extremity greater than the 30 percent previously awarded.[5] The period of the increased award, equivalent to 46.08 weeks of compensation, ran from June 28, 2018 to May 16, 2019.

LEGAL PRECEDENT

The schedule award provisions of FECA[6] and its implementing regulations[7] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted

[5] The Board notes that on its face, the September 12, 2018 decision noted zero percent additional permanent impairment of the left lower extremity and an additional 16 percent permanent impairment of the "LLE." Based on the medical evidence in support of the increased schedule award, the decision should have referred to an additional 16 percent permanent impairment of the right lower extremity ("RLE"). The Board finds that the decision reference to the left lower extremity is a harmless typographical error.

[6] 5 U.S.C. § 8107.

[7] 20 C.F.R. § 10.404.

the A.M.A., *Guides* as the uniform standard applicable to all claimants.[8] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[9]

No schedule award is payable for a member, function, or organ of the body not specified in FECA or in the regulations.[10] Because neither FECA nor the regulations provide for the payment of a schedule award for the permanent loss of use of the back,[11] no claimant is entitled to such an award.[12] However, in 1966, amendments to FECA modified the schedule award provision to provide for an award for permanent impairment to a member of the body covered by the schedule regardless of whether the cause of the impairment originated in a scheduled or nonscheduled member. As the schedule award provision of FECA includes the extremities, a claimant may be entitled to a schedule award for permanent impairment to an extremity even though the cause of the impairment originated in the spine.[13]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based impairment (DBI) method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[14] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment of the CDX, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[15] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[16]

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.[17]

The standards for evaluation of permanent impairment of an extremity under the A.M.A., *Guides* are based on all factors that prevent a limb from functioning normally, such as pain, sensory

[8] *Id.* at § 10.404(a); *see also Bernard A. Babcock, Jr.*, 52 ECAB 143 (2000).

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[10] *Henry B. Floyd, III*, 52 ECAB 220 (2001).

[11] FECA specifically excludes the back from the definition of "organ." 5 U.S.C. § 8101(19).

[12] *Thomas Martinez*, 54 ECAB 623 (2003).

[13] *See Thomas J. Engelhart*, 50 ECAB 319 (1999).

[14] A.M.A., *Guides*, *supra* note 5 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[15] *Id.* at 493-556.

[16] *Id*. at 521.

[17] *A.R.*, Docket No. 19-0250 (issued May 6, 2019); *M.J.*, Docket No. 17-1776 (issued December 19, 2018); *P.R.*, Docket No. 18-0022 (issued April 9, 2018). *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (March 2017).

deficit, and loss of strength.[18] Also, it is axiomatic that in determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[19]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish more than 30 percent permanent impairment of the left lower extremity and 46 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

OWCP accepted appellant's claims for lumbar strain, lumbar spondylosis, spinal stenosis, nonunion of lumbar fusion.[20] By decision dated April 4, 2013, under OWCP File No. xxxxxx564, it granted him schedule award compensation for 28 percent permanent impairment of each lower extremity. On September 28, 2016 appellant filed a claim for an increased schedule award due to his employment injuries.

Appellant's physicians, Dr. Ellis and Dr. Maitino, utilized the DBI method to rate bilateral lower extremity impairment due to bilateral hip arthroplasties. However, neither physician addressed neurologic impairment of the lower extremities originating in the spine. OWCP therefore obtained a second opinion from Dr. Brown regarding the appropriate percentage of permanent lower extremity impairment due to all accepted employment conditions. In an April 26, 2017 report, Dr. Brown utilized the DBI method to find 45 percent impairment of the right lower extremity due to right hip arthroplasty and spinal nerve root impairment, and 28 percent permanent impairment of the left lower extremity due to a left hip strain and spinal nerve root impairment.

Dr. Slutsky, a DMA, agreed with the percentages of spinal nerve root impairment found by Dr. Brown. He opined that appellant had 30 percent permanent impairment of each lower extremity based only on the employment conditions accepted under OWCP File No. xxxxxx075.

By decision dated August 25, 2017, under File No. xxxxxx075, OWCP granted appellant a schedule award for an additional two percent permanent impairment of each lower extremity. It set aside the August 25, 2017 schedule award by decision dated December 7, 2017 and remanded the claim to obtain a supplemental report from Dr. Brown. Dr. Brown provided a June 28, 2018 addendum report finding 45 percent permanent impairment of the right lower extremity and 29 percent permanent impairment of the left lower extremity based on the same tables and grading schemes as his prior report.

The DMA reviewed Dr. Brown's addendum report and concurred with the bilateral nerve root impairment percentages and right hip regional impairment, but disagreed with his percentage

[18] *C.H.*, Docket No. 17-1065 (issued December 14, 2017); *E.B.*, Docket No. 10-0670 (issued October 5, 2010); *Robert V. Disalvatore*, 54 ECAB 351 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

[19] *C.H.*, *id.*; *C.K.*, Docket No. 16-1294 (issued January 13, 2017); *P.W.*, Docket No. 16-0684 (issued October 3, 2016); *J.C.*, Docket No. 15-1780 (issued March 17, 2016); *Peter C. Belkind*, 56 ECAB 580 (2005).

[20] The Board notes that OWCP also accepted male erectile dysfunction, neuromuscular dysfunction of the bladder, urinary urgency and frequency, and neurogenic bowel. There is no schedule award claim of record for these conditions.

totals. For each lower extremity, the DMA utilized the Combined Values Chart to combine 13 percent L5 impairment, 12 percent S1 impairment, and 9 percent L4 impairment to equal 30 percent permanent impairment. He combined the 30 percent impairment for nerve root impingement with 23 percent impairment due to right hip arthroplasty to equal 46 percent permanent impairment of the right lower extremity. By decision dated September 12, 2018, OWCP granted appellant an additional 16 percent impairment of the right lower extremity.

The Board finds that the DMA properly applied the A.M.A., *Guides* and *The Guides Newsletter* to find that appellant had no more than 30 percent permanent impairment of the left lower extremity as previously awarded, and 46 percent permanent impairment of the right lower extremity. As appellant has not submitted evidence establishing greater permanent impairment, he has not met his burden of proof.

On appeal appellant contends that OWCP should not have reduced the September 28, 2018 schedule award for 46 permanent impairment of the right lower extremity due to hip arthroplasty under File No. xxxxxx075 based on the 28 percent previously awarded for spinal nerve root impairment under File No. xxxxxx564. He asserts that OWCP should not have combined the claims. As explained above, however, the DMA properly calculated the schedule award based on all conditions which affected the functioning of the limb.

Appellant may request a schedule award or increased schedule award at any time based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish more than 30 percent permanent impairment of the left lower extremity and 46 percent permanent impairment of the right lower extremity, for which he previously received schedule award compensation.

ORDER

IT IS HEREBY ORDERED THAT the September 12, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 16, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board